Seattle Children’s Alyssa Burnett Adult Life Center Intake Form

Thank you for submitting an intake form to the Seattle Children’s Alyssa Burnett Center (ABC)! We are excited to welcome more participants and families to the community growing here, and look forward to meeting you/your adult.

In addition to this intake form, please submit all of the following that apply to you/your adult:

- Person Centered Service Plan (PCSP- available through your DDA case manager): This assessment is done with a DDA case manager on an annual basis. The form is titled “Person Centered Service Plan (PCSP) Current Annual DDD Assessment Details”.
- IEP (Individualized Educational Program): This document is created for individuals in special education programs in public schools, to assist individuals in reaching their educational objectives.
- Care plans or tips from supported living services or group homes.

*Please do not drop off the form in person, we ask that you submit the form by email, fax, or mail.

- Email: abcintake@seattlechildrens.org
- Fax: 206-985-3341
- Mail: 19213 Bothell Way NE, Bothell, WA 98011

Next steps after we receive your intake form:

1. **Waitlist Confirmation:** Once we process all of the necessary paperwork, you will receive an email confirmation.

2. **Schedule Intake appointment:**
   - When an opening becomes available, you will receive an email with a link to schedule your intake appointment. Dates are limited and fill up quickly so timely responses are encouraged.
   - Please select your desired intake appointment. You will receive an email confirmation when this step is complete.
   - The intake appointment is a casual opportunity to introduce you/your adult to the center and get to know each other so that we can determine best fit for classes at the center. During the appointment, we will tour the building, answer any questions you might have, and also assess which level of classes and caregiver needs we think would be best suited for you/your adult.
Date: __________________
Name of individual filling out this form: __________________

Participant Information

Name: ___________________________ Birth Date: ______________
Address: _______________________________________________________
City: ___________________________ State: __________ Zip: __________
Age: _______ years Height: _____ feet _____ inches Weight: _____ pounds
Home Phone: _________________ Work Phone: _________________
Cell Phone: _______________ Email: _________________________________
Gender: O Female   O Male       Legal Guardian: ________________________________
Living Arrangement: _______________________________________________
Does Participant typically require a 1:1 Aide or Care Giver? O Yes   O No
If yes, please explain: ________________________________________________
Agency: __________________________________________________________
Disability/Diagnosis: _________________________________________________
Date of Diagnosis/Injury: _____ month _____ year
Ethnicity: ___________________________ Race: ____________________________

Registration/Scheduling Contact

Name: ___________________________ Relationship to Participant: _____________
Address: ______________________________________________________________
City: ___________________________ State: ______ Zip: ______________
Home Phone: _________________ Work Phone: ______________________________
Cell Phone: _______________ Email: _______________________________________

Please check if this contact is also the contact for any of the following:
  □ Billing
  □ Transportation
  □ Behaviors
Billing Contact (if different from the Registration/Scheduling Contact)
Name: ________________________ Relationship to Participant: _____________
Address: _________________________________________________________________
City: _________________________ State: _____ Zip: _________________
Home Phone: _________________ Work Phone: _________________________
Cell Phone: _________________ Email: ____________________________________

Caregiver (if different from the Registration/Scheduling Contact)
Name: ________________________ Relationship to Participant: _____________
Address: _________________________________________________________________
City: _________________________ State: _____ Zip: _________________
Home Phone: _________________ Work Phone: _________________________
Cell Phone: _________________ Email: ____________________________________

Medical Emergency Information
Primary Insurance: ____________________________ Policy #: ________________
Secondary Insurance: ____________________________ Policy #: ________________

Which funding sources apply to you
☐ Private Pay
☐ DDA (If checked, please fill out case manager information below)
   Case manager name_________________ Phone # ______________
   E-mail________________________
☐ Waiver (If checked, please fill out case manager information below)
   Case manager name_________________ Phone # ______________
   E-mail________________________
Communication

From the options below please select the one that most applies to you:

Please check all that apply and provide details.

☐ Completely Verbal-Participant can fluently communicate with others
☐ Limited Verbal-Participant can communicate statements/few words
☐ Non-Verbal-Participant does not verbally communicate

Please select the way(s) that you communicate, and provide details:

☐ Vocal: _________________________________________________________
☐ Sign Language: ___________________________________________________
☐ Communication Device: _____________________________________________
☐ Pictures: _________________________________________________________

Receptive Abilities

Please check all that apply and provide details:

☐ Understands 2-step directions: _______________________________________
☐ Understands spoken words: ___________________________________________
☐ Reading Ability (estimated grade level): ________________________________
☐ Gestures: _________________________________________________________
☐ Other: ___________________________________________________________

Describe any communication suggestions or modifications to be aware of:

____________________________________________________________________

Experience

Have you ever participated in a similar program? ☐ Yes ☐ No Where? _______________

What type of work are you currently doing or have you done in the past?

____________________________________________________________________

What type of volunteering are you currently doing or have you done in the past?

____________________________________________________________________
Are you currently attending school or a transition program? ☐ Yes ☐ No

Name of School: ___________________________  Highest academic grade level completed: _____________

Behavior

What challenging behaviors do you have (check all that apply and describe what the behaviors look like – the more detail, the better):

☐ Tantrums (example of behavior, such as: high pitched voice, crying):

☐ Physical aggression (example of behavior, such as: strikes, bites, tears clothes of others):

☐ Verbal aggression (example of behavior, such as: yelling or swearing at others):

☐ Property destruction (example: attempting or breaking furniture, putting holes in walls):

☐ Elopement (example of behavior, such as: running away from buildings):

☐ Self-Injurious behavior (example of behavior, such as: pinching, biting or hitting self):

☐ Other behavior(s) not listed above:

☐ No challenging behaviors

What are some things or situations that could trigger a behavior?


If a behavior happens, what can we do to help?

What can you do to cope when you are triggered?

Fill out the following on how to work best with you:

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**Transportation**

How do you plan on getting to Seattle Children's Alyssa Burnett Adult Life Center?

Please check all that apply:

- [ ] Own Transportation
- [ ] Metro
- [ ] Access
- [ ] DART
- [ ] Other: ______________________

Can you be dropped off alone?  ○ Yes  ○ No

Who is authorized to pick up the participant? ______________________

Does the participant have the permission to leave the center independently throughout the day?  ○ Yes  ○ No
Mobility
Do you have a mobility challenge? ○ Yes ○ No
If yes, please check all that apply:

☐ Balance □ Dexterity  □ Use crutches
☐ Coordination □ Visual Impairment □ Use Manual Wheelchair
☐ Endurance/Fatigue □ Spinal Cord Injury □ Use Power Wheelchair
☐ Hemiplegia □ Use Cane □ Use Walker

Other: .........................................................................................................................

Wheelchair users only:
How often do you use your chair?

☐ Always  ☐ Only when fatigued  ☐ Only when outside  ☐ Only away from home

Do you operate the wheelchair independently? ○ Yes ○ No

Do you need assistance with transfers? ○ Yes ○ No (If yes, please select from the following)

☐ Minimal Assist  □ Moderate Assist  □ Always

Please share any other mobility concerns:
........................................................................................................................................

Toileting
Toileting:  □ Independent □ Partial Assist □ Total Assist

Bladder needs:  □ Incontinent □ Needs reminders □ Needs to go very often

Additional details: ...........................................................................................................

Dietary/Eating

Dietary Needs:

☐ None □ Vegetarian □ Diabetic □ Gluten/Casein Free

☐ Thick Liquids □ Tube

☐ Other Restrictions (such as fluid): ..................................................................................
History of Choking?  O Yes  O No  If yes, please explain:

Food Allergies?  O Yes  O No  If yes, please list:

Do you need assistance with eating?  □ None  □ Partial Assist  □ Total Assist
Please explain: ________________________________________________________________

Health
Do you have any health concerns you would like us to know about?  O Yes  O No
If yes, please explain: __________________________________________________________________

Please list any medications that you are currently taking, including over-the-counter:
________________________________________________________________________________

Please list all non-food allergies:

________________________________________________________________________________

Do you have a seizure disorder?  O Yes  O No
If yes, please check the type of seizure
□ Grand Mal  □ Absence  □ Myoclonic  □ Clonic
□ Tonic  □ Atonic  □ Not sure
How frequently do you have seizures? _____________________________________________

What is the current status of your seizure disorder?  O Active  O Controlled
Describe your seizure. Do you have any warning? What is the after effect of the seizure?
________________________________________________________________________________
________________________________________________________________________________

Describe specific care required in the event of a seizure and recovery time:
________________________________________________________________________________
________________________________________________________________________________
Interests

Please check any boxes that apply and use the additional space to provide details on specific likes and dislikes:

☐ Music: __________________________________________

☐ Instrument(s): ____________________________________

☐ Singing: __________________________________________

☐ Art: ______________________________________________

☐ Cooking: __________________________________________

☐ Exercise: __________________________________________

☐ Sports: ____________________________________________

☐ Swimming: _________________________________________

☐ Yoga: _____________________________________________

☐ Outdoors: __________________________________________

☐ Animals: __________________________________________

☐ Gardening: _________________________________________

☐ Drama: ____________________________________________

☐ Humor: ____________________________________________

☐ Movies: ____________________________________________

☐ Technology: _________________________________________

☐ Reading: __________________________________________

☐ Vocational Training: _________________________________

☐ Independent Living: _________________________________

☐ Community Outings: _________________________________

☐ Other: ____________________________________________

☐ What are your strengths: ______________________________

Please share your top priorities for classes and activities:

1) __________________________________________________

2) __________________________________________________

3) __________________________________________________
Goals

What are your current goals?

What would you hope to see as an outcome from attending Seattle Children’s Alyssa Burnett Adult Life Center?

Any additional information you would like us to know?

Thank you for completing this intake form. Please call us if you have any questions: (425) 488-6173.

Save a copy of the intake form to your computer and then email a copy to abcintake@seattlechildrens.org

Or print a copy and mail to: Alyssa Burnett Adult Life Center
19213 Bothell Way NE
Bothell, WA 98011

Or print a copy and fax to: (206) 985-3341

Please attach any additional applicable paperwork (i.e. PCSP, IEP, care plans, etc.) with the submission of your intake form.